

Which physician are you seeing today: OWENS LEE ARCHER BRIEF LINDHOLM
(Please circle)

Today's Date: _____

Patient #: _____

Last Name: _____ Middle: _____ First: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

S.S.#: _____ Birthdate: _____ Age: _____

Sex: Male _____ Female _____ Marital Status: _____

Employer Name & Address: _____

Or if patient is a student; school's name & address: _____

Parent's Name & DOB (if patient is a minor): _____ **DOB:** _____

Name of Spouse: _____ DOB: _____ Age: _____

S.S.#: _____ Business Phone: _____

Employer's Name & Address: _____

HOW DID YOU HEAR ABOUT US?: _____

Name of Family Physician: _____ Office Phone: _____

Address: _____

(PRIMARY INSURANCE)

Name of Insurance Company: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber's Name: _____ S.S.#: _____ DOB: _____

Group #: _____ Policy #: _____

Referral Required ? ___ Yes ___ No Co-Pay ? ___ Yes ___ No Amount: _____

(SECONDARY INSURANCE)

Name of Insurance Company: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip: _____

Subscriber's Name: _____ S.S.#: _____ DOB: _____

Group #: _____ Policy #: _____

Referral Required ? ___ Yes ___ No Co-Pay ? ___ Yes ___ No Amount: _____

Were you injured at work ? _____ YES _____ NO

Date of Injury: _____

Did you have an auto accident ? _____ YES _____ NO

Date of Accident: _____

****** STOP ******

IF YOU ANSWERED “YES” TO EITHER OF THE QUESTIONS ABOVE, YOU MUST COMPLETE AN ADDITIONAL FORM. PLEASE ASK THE FRONT DESK STAFF FOR THIS FORM.

PATIENT AGREEMENT

To accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. While we are pleased to provide this service to you, it is very difficult for us to keep track of all the individual requirements of each plan. Each plan has different restrictions regarding how often services may be rendered and, more importantly, where you should obtain these services. Even within a single insurance company, the plans differ; depending on what type of contract your employer has negotiated. Providing the highest quality medical care for our patients is our primary concern. We are more than willing to provide that care within your insurance guidelines, whenever possible.

Most insurance companies require prior approval and/or referrals for each office visit. It is your responsibility to obtain these. If we do not receive authorization, payment is due at the time of service.

If you do not inform us of special requirements by your plan and we order services that you need, such as lab work, hospitalization, or supplies that are not covered by your plan, we may bill you directly for those charges. Payment of these services may be your responsibility. In addition, most managed care programs require the patient to pay a co-payment at the time of service. It is your responsibility to fulfill this obligation.

It is my understanding that if I become a patient of *NJOS*, I agree to the following:

AUTHORIZATION to RELEASE INFORMATION:

I am authorizing you to release any medical information necessary to process insurance claims and that you might feel appropriate concerning my condition to any insurance company, attorney, or adjuster in order to receive reimbursement on any charges incurred by me as a result of services rendered by you professionally.

AUTHORIZATION to PAY DOCTOR DIRECTLY (ASSIGNMENT):

I authorize direct payment to you of any sum that I owe you, now or in the future, from any insurance company that is obligated to reimburse me for charges incurred in your office, or any other services rendered by you in any other facility, in part or full or from my attorney out of the proceeds from my settlement. A photocopy of this form is acceptable for payment.

ASSIGNMENT of CAUSE of ACTION:

I hereby assign and give you the right to take actions against any insurance company that is obligated by contract to make payment to me. I authorize you to take action in either my name or your name to resolve any matter. It is understood that all reasonable efforts will be made to collect from the insurance company before I will be made to be responsible for this bill. I do understand that whatever amounts that are not collected from the insurance company will become my responsibility and I am to pay these charges as soon as possible.

I HAVE READ AND UNDERSTAND THE OFFICE POLICIES STATED ABOVE, AGREE TO ACCEPT RESPONSIBILITY AS DESCRIBED, AND GIVE THE AUTHORIZATIONS INDICATED.

Signature of Patient or Guardian (if minor patient)

Date